Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FORT DUNCAN MEDICAL CENTER
3255 W PIONEER PARKWAY
PANTEGO TX 76013

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-3198-01

MFDR Date Received
June 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the new fee schedule this account qualifies for an Outlier payment…"

Amount in Dispute: $3,772.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier believes the paid procedure codes better reflect the services provided and that reimbursement was made per the DWC fee Guidelines."

Response Submitted by: Chartis, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 3 – 31, 2012	Outpatient Hospital Services	$3,772.32	$3,772.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 24, 2012
   - 1 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 2 – (W1) Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated May 29, 2012

- 1 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 2 – (W1) Workers Compensation State Fee Schedule Adjustment

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 82962, date of service January 31, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.32. 125% of this amount is $4.15
   - Procedure code 82962, date of service January 23, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.32. This amount multiplied by 2 units is $6.64. 125% of this amount is $8.30
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Medicare Clinical Fee Schedule is $3.32. This amount multiplied by 2 units is $6.64. 125% of this amount is $8.30

- Procedure code 82962, date of service January 26, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.32. This amount multiplied by 2 units is $6.64. 125% of this amount is $8.30
- Procedure code 82962, date of service January 27, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.32. This amount multiplied by 2 units is $6.64. 125% of this amount is $8.30
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- Procedure code 85610, date of service January 10, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.56. 125% of this amount is $6.95
- Procedure code C1300, date of service January 23, 2012, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0659, which, per OPPS Addendum A, has a payment rate of $104.83. This amount multiplied by 60% yields an unadjusted labor-related amount of $62.90. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $50.75. The non-labor related portion is 40% of the APC rate or $41.93. The sum of the labor and non-labor related amounts is $92.68 multiplied by 4 units is $370.72. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $370.72. This amount multiplied by 200% yields a MAR of $741.44.
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specific reimbursement amount for this line is $370.72. This amount multiplied by 200% yields a MAR of $741.44.

- Procedure code C1300, date of service January 26, 2012, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0659, which, per OPPS Addendum A, has a payment rate of $104.83. This amount multiplied by 60% yields an unadjusted labor-related amount of $62.90. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $50.75. The non-labor related portion is 40% of the APC rate or $41.93. The sum of the labor and non-labor related amounts is $92.68 multiplied by 4 units is $370.72. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $370.72. This amount multiplied by 200% yields a MAR of $741.44.
- Procedure code C1300, date of service January 27, 2012, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0659, which, per OPPS Addendum A, has a payment rate of $104.83. This amount multiplied by 60% yields an unadjusted labor-related amount of $62.90. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $50.75. The non-labor related portion is 40% of the APC rate or $41.93. The sum of the labor and non-labor related amounts is $92.68 multiplied by 4 units is $370.72. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $370.72. This amount multiplied by 200% yields a MAR of $741.44.
- Procedure code C1300, date of service January 30, 2012, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0659, which, per OPPS Addendum A, has a payment rate of $104.83. This amount multiplied by 60% yields an unadjusted labor-related amount of $62.90. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $50.75. The non-labor related portion is 40% of the APC rate or $41.93. The sum of the labor and non-labor related amounts is $92.68 multiplied by 4 units is $370.72. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $370.72. This amount multiplied by 200% yields a MAR of $741.44.
- Procedure code C1300, date of service January 31, 2012, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0659, which, per OPPS Addendum A, has a payment rate of $104.83. This amount multiplied by 60% yields an unadjusted labor-related amount of $62.90. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $50.75. The non-labor related portion is 40% of the APC rate or $41.93. The sum of the labor and non-labor related amounts is $92.68 multiplied by 4 units is $370.72. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $370.72. This amount multiplied by 200% yields a MAR of $741.44.
- Procedure code 99213, date of service January 6, 2012, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0605, which, per OPPS Addendum A, has a payment rate of $72.18. This amount multiplied by 60% yields an unadjusted labor-related amount of $43.31. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $34.94. The non-labor related portion is 40% of the APC rate or $28.87. The sum of the labor and non-labor related amounts is $63.81. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $63.81. This amount multiplied by 200% yields a MAR of $127.62.
- Procedure code 99213, date of service January 13, 2012, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0605, which, per OPPS Addendum A, has a payment rate of $72.18. This amount multiplied by 60% yields an unadjusted labor-related amount of $43.31. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $34.94. The non-labor related portion is 40% of the APC rate or $28.87. The sum of the labor and non-labor related amounts is $63.81. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $63.81. This amount multiplied by 200% yields a MAR of $127.62.
- Procedure code 99213, date of service January 20, 2012, has a status indicator of V, which denotes a clinic

or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0605, which, per OPPS Addendum A, has a payment rate of $72.18. This amount multiplied by 60% yields an unadjusted labor-related amount of $43.31. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $34.94. The non-labor related portion is 40% of the APC rate or $28.87. The sum of the labor and non-labor related amounts is $63.81. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $63.81. This amount multiplied by 200% yields a MAR of $127.62.

- Procedure code 99213, date of service January 24, 2012, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0605, which, per OPPS Addendum A, has a payment rate of $72.18. This amount multiplied by 60% yields an unadjusted labor-related amount of $43.31. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $34.94. The non-labor related portion is 40% of the APC rate or $28.87. The sum of the labor and non-labor related amounts is $63.81. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $63.81. This amount multiplied by 200% yields a MAR of $127.62.
- Procedure code 99214, date of service January 3, 2012, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0606, which, per OPPS Addendum A, has a payment rate of $95.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $57.12. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $46.08. The non-labor related portion is 40% of the APC rate or $38.08. The sum of the labor and non-labor related amounts is $84.16. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $84.16. This amount multiplied by 200% yields a MAR of $168.32.
- Procedure code 99214, date of service January 10, 2012, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0606, which, per OPPS Addendum A, has a payment rate of $95.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $57.12. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $46.08. The non-labor related portion is 40% of the APC rate or $38.08. The sum of the labor and non-labor related amounts is $84.16. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $84.16. This amount multiplied by 200% yields a MAR of $168.32.
- Procedure code 99214, date of service January 17, 2012, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0606, which, per OPPS Addendum A, has a payment rate of $95.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $57.12. This amount multiplied by the annual wage index for this facility of 0.8068 yields an adjusted labor-related amount of $46.08. The non-labor related portion is 40% of the APC rate or $38.08. The sum of the labor and non-labor related amounts is $84.16. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $84.16. This amount multiplied by 200% yields a MAR of $168.32.

3. The total allowable reimbursement for the services in dispute is $6,266.42. The amount previously paid by the insurance carrier is $2,468.88. The requestor is seeking additional reimbursement in the amount of $3,772.32. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,772.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,772.32, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 24, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.